(2) A reinoculation of the patient with the germ caused the formation of a pustule after seven days' incubation;

(3) And because an immunizing substance was found in the blood of the patient, which was capable of rendering mice immune from the disease or acting therapeutically upon infected mice. This immunizing substance was still present in small amount in the blood at the seventh week.

No such disease as this has been heretofore described.—*Verhandlungen der deutschen Gesellschaft für Chirurgie*, XXIII Kongress, 1894.

JAMES P. WARBASSE (Brooklyn).

## OPERATIVE SURGERY.

**Osteoplastic Resection of the Sacrum after the Method of Rydygier.** By F. KAMMERER (New York). The author reports six cases in which to gain access to the rectum he resorted to osteoplastic resection of the sacrum after the method of Rydygier. In this operation the soft parts are first divided along the left border of the sacrum by an incision beginning at the posterior superior spine of the ilium on the left side and running down to the tip of the coccyx, and thence in the median line to the anus. After division of the sacro-sciatic ligaments, the soft parts are detached from the anterior surface of the sacrum by the hand of the operator. A transverse incision is then added below the third sacral foramen, and the bone divided along this line with a chisel. The flap thus formed is now turned to the right side, and with a retractor inserted at the tip of the flap is easily held aside, and permits manipulations about the rectum to be made as readily as when the bone has been entirely removed.

The author reports that in his experience he has been impressed by the rapidity with which this preliminary operation can be done, and also by the fact that the osteoplastic resection is a much less bloody operation than the permanent removal of coccyx and sacrum by any one of the other methods which involved dissection of the soft parts from the posterior surface of the sacrum.

He recommends further the knee-elbow posture, with its distinct elevation of the pelvis, as the most desirable one for rectal surgery, since it controls hæmorrhage through elevation, gives excellent access to the field of operation, and facilitates manipulations with the chisel, the pelvis being supported by sand-bags placed under the anterior iliac spines.

When the nature of the case permits the flap to be returned to its place and sutured, the result will be an ideal one as regards restitution of the normal contour of the sacral region. In suturing the transverse incision the author has always passed the needle down to the bone, but has never included the bone itself in a suture by any device. Nevertheless, firm union of the bone-surfaces has always followed. Where secondary operations have necessitated renewed elevation of the flap, he has not found the secondary operation any more tedious than the first; greater care only being required to avoid the rectum which has become drawn close to the anterior face of the sacrum by cicatricial contraction. In cases in which tamponnade of the wound cavity is necessary for some time, the temptation to suture the flap back should be resisted, and the wound cavity be left entirely open, notwithstanding some retraction of the flap and some deformity will develop after a time. Any such deformity can be readily remedied by a subsequent slight plastic operation.—*Medical Record*, July 28, 1894.

## ABDOMEN.

**I. Splenectomy for Enlarged Spleen with Twisted Pedicle followed by Recovery.** By W. J. CONKLIN, M.D. (Dayton, Ohio). The patient was a woman, twenty-nine years of age, the subject of an enlarged spleen, presumably of malarial origin. No examinations of the blood were made, but the symptoms of leukæmia were absent. She had for some months been cognizant of a freely movable tumor in the lower abdomen. An abdominal section demonstrated the tumor to be the enlarged and displaced spleen. She also had a small cyst of one ovary, which was removed. The